TENDER ONES
THERAPY SERVICES
T O T S
www.tenderones.com

2089 Teron Trace Suite 120
Dacula, GA 30019
Office: 770-904-6009 Fax: 770-904-2357

Constraint Induced Movement Therapy Intensive Screener

1. Does your child have any previous experience with CIMT? ☐ Yes ☐ No
   a. If yes, please describe and provide dates

   _____

   _____
2. Is your child currently receiving occupational therapy services? ☐ Yes ☐ No
   a. If yes, how frequently?_____
3. Has your child had any surgeries/procedures involving the affected arm/hand? ☐ Yes ☐ No
   a. If yes, please explain and provide the dates

   _____

   _____
4. Does your child currently have any precautions? ☐ Yes ☐ No
   a. If yes, please explain

   _____

   _____
5. Which hand is your child's dominant hand? ☐ R ☐ L
6. Does your child have a splint? ☐ Yes ☐ No
   a. If yes, please specify the type of splint and wearing schedule

   _____

   _____
7. Does your child have tone (high or low) in the affected arm/hand? ☐ Yes ☐ No
8. Does your child demonstrate any usage of the affected arm/hand? ☐ Yes ☐ No
   a. Can he/she hold a tennis ball? ☐ Yes ☐ No
   b. Can he/she hold a golf ball? ☐ Yes ☐ No
   c. Can he/she pick up a cheerio? ☐ Yes ☐ No
   d. Please describe your child's movement abilities in his/her affected arm/hand

   _____

   _____
9. Does your child have full sensation in the affected UE? ☐ Yes ☐ No
   a. If no, please explain

   _____
10. Please describe the major concerns you have about your child

    _____

    _____